BLUMENFELD FAMILY CHIROPRACTIC

DATE_____

E-MAIL ADDRESS_____

1. REQUIRED FOR YOUR CASE HISTORY FILE:

NAME_____ S.S. #_____

ADDRESS_____CITY_____STATE___ZIP_____

TELEPHONE ( ) _____ AGE _____ BIRTHDATE _____

SEX_____ MARITAL STATUS (CIRCLE ONE) M S W D NO. OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

WORK TELEPHONE ( )_____ SPOUSE'S NAME_____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

WHY DID YOU CHOOSE THIS OFFICE? _____

MAJOR COMPLAINTS AND SYMPTOMS_____

WHEN DID YOU FIRST NOTICE THIS? _____

HAS THIS EVER HAPPENED BEFORE? _____ WHEN? _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

HEIGHT_____ WEIGHT_____

SMOKING STATUS _____

FEMALE PATIENTS: ARE YOU PREGNANT? ___ YES ___ NO

OTHER COMMENTS: _____

_____

NAME OF NEAREST LIVING RELATIVE_____

ADDRESS_____ PHONE ( ) _____

2. INSURANCE INFORMATION: (PLEASE CHECK ONE OR MORE OF THE FOLLOWING)

AUTO ACCIDENT ☐ WORK INJURY ☐ GROUP HEALTH INSURANCE ☐

PRIVATE HEALTH INSURANCE ☐ MEDICARE ☐ CASH PAYMENT ☐

NAME OF INSURANCE CO._____

GROUP#_____ POLICY #_____ CLAIM #_____

ADDRESS_____

INSURANCE PHONE ( ) _____ AGENT_____

3. ACCIDENT-INJURY INFORMATION:

DATE_____ TIME_____AM/PM POLICE REPORT MADE? _____

DESCRIPTION OF
ACCIDENT/INJURY_____

_____

_____

DRIVER'S LICENSE STATE/NUMBER_____

PATIENT'S SIGNATURE_____

AGREEMENT OF PAYMENT FOR SERVICES RENDERED

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND ME. THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNED_____WITNESSED_____

DATE_____

NOTICE OF NON-DISCRIMINATION

THIS OFFICE COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY, OR SEX, INCLUDING DISCRIMINATION BASED ON PREGNANCY, GENDER IDENTITY, AND SEX STEREOTYPING. ADDITIONALLY, OUR OFFICE DOES NOT EXCLUDE PEOPLE OR TREAT THEM DIFFERENTLY BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY, OR SEX. YOU MAY ACCESS THE NONDISCRIMINATION AND ACCESSIBILITY NOTICE.

Blumenfeld Family Chiropractic

Consent to Chiropractic Services

I, _____, authorize the performance upon myself any of the following procedures as deemed clinically necessary:

-Physical Examination
-Regional Examination
-Chiropractic Adjustments
-Physical Therapeutic Modalities
-Blood Work
-Urine Analysis
-Other Laboratory Services
-Radiographic Examination
-Advanced Imaging

I understand there are charges for these services and specific charges will be explained to me upon request.

These tests are to be performed by Dr. Jason H Blumenfeld.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above named doctor may consider necessary or advisable in the course of my health care. I understand there are fees for these services and I will be charged accordingly. Specific charges will be explained to me upon request.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above mentioned doctor.

Date: _____ Signed: _____

Witness: _____ Relationship: _____

<u>FEMALE PATIENTS ONLY:</u> This is to certify that to the best of my knowledge I am NOT pregnant and that Dr. Blumenfeld has permission to take X-rays. ***If you even suspect that you might be pregnant, please inform the doctor. ***

Date of Last Menstrual Period: _____Signed:_____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA"). I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE IT *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE THE OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT NOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:	INITIALS:	REASON:

SYMPTOMS

GENERAL

	severe	mild	none
Allergy	☐	☐	☐
Chills	☐	☐	☐
Convulsions	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Headache	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of weight	☐	☐	☐
Nervousness	☐	☐	☐
Neuralgia	☐	☐	☐
Numbness	☐	☐	☐
Sweats	☐	☐	☐
Wheezing	☐	☐	☐
Weakness in arms, legs	☐	☐	☐

MUSCLE AND JOINT

Backache	☐	☐	☐
Faulty posture	☐	☐	☐
Foot trouble	☐	☐	☐
Hernia	☐	☐	☐
Pain between shoulders	☐	☐	☐
Painful tailbone	☐	☐	☐
Spinal curvature	☐	☐	☐
Stiff neck	☐	☐	☐
Tremors	☐	☐	☐
Swollen joints	☐	☐	☐

CARDIO-VASCULAR

Hardening of arteries	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Paralytic stroke	☐	☐	☐
Poor circulation	☐	☐	☐
Previous stroke	☐	☐	☐
Rapid beating heart	☐	☐	☐
Slow beating heart	☐	☐	☐
Swelling of ankles	☐	☐	☐

SYMPTOMS

GASTRO-INTESTINAL

	severe	mild	none
Belching or gas	☐	☐	☐
Colitis	☐	☐	☐
Colon trouble	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficult digestion	☐	☐	☐
Distention of abdomen	☐	☐	☐
Excessive hunger	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Hemorrhoids	☐	☐	☐
Jaundice	☐	☐	☐
Liver trouble	☐	☐	☐
Nausea	☐	☐	☐
Pain over stomach	☐	☐	☐
Poor appetite	☐	☐	☐
Vomiting	☐	☐	☐
Vomiting of blood	☐	☐	☐

E.E.N.T.

Asthma	☐	☐	☐
Crossed eyes	☐	☐	☐
Deafness	☐	☐	☐
Dental decay	☐	☐	☐
Earache	☐	☐	☐
Ear discharge	☐	☐	☐
Ear noises	☐	☐	☐
Enlarged glands	☐	☐	☐
Enlarged thyroid	☐	☐	☐
Eye pain	☐	☐	☐
Failing vision	☐	☐	☐
Frequent colds	☐	☐	☐
Hay fever	☐	☐	☐
Hoarseness	☐	☐	☐
Gum trouble	☐	☐	☐
Nasal congestion	☐	☐	☐
Nose bleeds	☐	☐	☐
Near sightedness	☐	☐	☐
Sinus infection	☐	☐	☐
Sore throat	☐	☐	☐
Tonsillitis	☐	☐	☐

SYMPTOMS

RESPIRATORY

	severe	mild	none
Chest pain	☐	☐	☐
Chronic cough	☐	☐	☐
Difficult breathing	☐	☐	☐
Spitting up blood	☐	☐	☐
Spitting up phlegm	☐	☐	☐

SKIN

Boils	☐	☐	☐
Bruises	☐	☐	☐
Dryness	☐	☐	☐
Hives or allergy	☐	☐	☐
Itching	☐	☐	☐
Sensitive skin	☐	☐	☐
Skin eruptions	☐	☐	☐
Varicose veins	☐	☐	☐

GENITO-URINARY

Bed wetting	☐	☐	☐
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Inability to control urine	☐	☐	☐
Kidney infection	☐	☐	☐
Kidney stones	☐	☐	☐
Painful urination	☐	☐	☐
Prostate trouble	☐	☐	☐

FOR WOMEN ONLY

Premenstrual tension	☐	☐	☐
Congested breast	☐	☐	☐
Menstrual cramps	☐	☐	☐
Menstrual backache	☐	☐	☐
Excessive flow	☐	☐	☐
Hot flashes	☐	☐	☐
Irregular cycle	☐	☐	☐
Lumps in breast	☐	☐	☐
Menopausal symptoms	☐	☐	☐
Painful menstruation	☐	☐	☐
Vaginal discharge	☐	☐	☐
Are you pregnant?		Yes ☐	No ☐

NAME _____

NOTICE OF PRIVACY PRACTICES
(MEDICAL VERSION)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for our visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July1, 2011, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of your office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA or to file a complaint:

The U.S. Department of Heath & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775